VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 31, 2019

Ms. Catherine Rooney, Manager
Harvey House Ltd
1860 Main Street
Castleton, VT 05735-7709

Dear Ms. Rooney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 4, 2019.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0380	A. BUILDING: _____ B. WING _____	C 09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVEY HOUSE LTD	1860 MAIN STREET CASTLETON, VT 05735

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R100	Initial Comments: An unannounced on-site complaint visit was made by the Division of Licensing and Protection on 9/4/19 to determine regulatory compliance with having Registered Nurse coverage. During the survey it was identified and confirmed that the facility is currently without a Registered Nurse and has not had coverage since December 2018. This was determined to represent a situation that requires Immediate Corrective Action (ICA) due to the risk to the safety of residents. The facility was notified of the need for ICA in writing on September 5, 2019, and in response, the facility submitted an Immediate Corrective Action plan on September 11, 2019.	R100		
R126 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary services to provide or arrange to meet the nursing and medical care needs for all residents of the facility. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include: During the investigation on 9/4/19, it was	R126	R126 RN will be notified of date resident will be admitted so the medication/care plan can be completed within 24hrs & the assesment completed within 14 days On day of admission will call nurse that resident has arrived so necessary paperwork can be completed	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: manager — (X6) DATE: 10/25/19

STATE FORM 6899 Y76I11 If continuation sheet 1 of 14

R126 - R178 POC accepted 10/25/19 BBartell RN/PMC

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R126	Continued From page 1 Identified and confirmed that the facility is currently without a Registered Nurse (RN) to provide nursing oversight and delegation of nursing tasks, and has been without RN coverage since December 31, 2018. Residents in the home are having medications administered by unlicensed staff, without RN review and direction. Resident #1 was admitted to the facility 3/6/19 and there is no evidence that a Registered Nurse (RN) did an assessment or reconciled his/her medications. There is no evidence that an RN completed a care plan for the resident. The care giver that was present in the home, stated on 9/4/19 at 8:30 AM, that the RN only checks off the resident's medications when they come to the facility. S/he further stated that the RN had not been in for a long time. The owner confirmed at 10:30 AM on 9/4/19, that there has been no RN coverage since December 2018 and no RN reviewed Resident #1 upon admission. It was further confirmed at this time, by the owner, that unlicensed staff have been giving medications to the resident without RN oversight	R126	R126	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation	R134		

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R134	Continued From page 2 implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that assessments were completed for 1 of 5 residents in the sample, Resident #1, within 14 days of admission. Further the resident's abilities regarding medication management was not assessed within 24 hours, and no nursing delegation was completed. Findings include: Resident #1 was admitted to the facility 3/6/19 and in reviewing the medical record, there is no evidence that an assessment was completed by a Registered Nurse (RN) within 14 days of admission. The owner confirmed on 9/4/19 at 10:30 AM that there has not been a completed assessment and medication review by an RN for Resident #1 and unlicensed staff have been providing care for the resident that s/he felt was necessary based on information s/he had obtained upon admission.	R134	R134 The RN will be notified of day resident will be admitted so within 24hrs so RN can assess for medication management	
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced	R135	The RN will be notified of the day of any new admission. This will be monitored by checking residents record 5 days after admission to be sure RN has completed assessment	

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R135	Continued From page 3 by: Based on staff interview and record review, the facility failed to have a licensed nurse assess 1 of 5 residents, Resident #1, within 14 days of admission, using an assessment instrument provided by the licensing agency. Findings include: There is no evidence that an assessment was completed within 14 days of the 3/6/19 admission. The resident requires medication administration. Confirmation was made by the owner on 9/4/19 at 10:30 AM that a 14-day assessment was not completed by a licensed nurse.	R135		
R136 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that resident assessments for 3 of 5 residents, Resident #2, 3 and 4, were reassessed annually. Findings include: Review of medical records on 9/4/19 presents that Resident #2 last had an assessment completed on 4/30/18, Resident #3 last	R136	All annual assessments have been completed for current residents by the RN This is reviewed every 3rd week of month by reviewing residents records	

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R136	Continued From page 4 assessment was completed by the Registered Nurse on 7/30/18 and Resident #4 was 8/31/18. The owner confirmed on 9/4/19 at 10:30 AM that there has not been a Registered Nurse available to complete the assessments.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure development of a written plan of care for 1 of 5 residents, Resident #1. Findings include: Resident #1 was admitted to the home on 3/6/19 and at the time of admission there is no evidence that a Registered Nurse (RN) was available for the facility to complete the plan of care. The owner confirmed on 9/4/19 at 10:30 AM that there was no RN to complete the plan of care.	R145	R145 All care plans have been completed for current residents by the RN This is monitored every 3rd week of month by reviewing residents records	
R146 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3)	R146		

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R146	Continued From page 5 Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there is no evidence that the facility provided a Registered Nurse to provide instructions and supervision to all direct care staff regarding the health care needs and delegation of nursing tasks as appropriate for 5 of 5 residents that live at the facility and one resident, Resident #1 in regards for direction for monitoring blood pressures after falls that were in relation to bouts of being dizzy. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include: During an interview with the care giver at the home, s/he stated that his/her duties were to monitor the residents while doing daily activities, helping them as they need, and s/he does medication management for the residents. There is no evidence that supervision from a Registered Nurse (RN) has been provided since December 2018 for the care of the residents and there is no evidence that an RN has assessed the staff that are medication delegated for greater than one year. The care giver at the home stated that s/he cannot recall the last time that the RN oversaw the medication administration and further stated that the RN only checks off all the medications when a resident comes to the facility. The caregiver also confirmed on 9/4/19 at 8:30 AM that if a resident has a fall, s/he assesses them to make sure they are okay and if they say "ow" s/he assumes there is an injury and calls the rescue squad.	R146	R146 All staff who provide medication management have been tested + instructed by the RN of the facility. All staff have been directed that if a resident has a medication change/fall/injury that the RN is to be notified immediately & recorded in the log This is reviewed every 3rd week of month by reviewing residents records	

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R146	Continued From page 6 Resident #1 had falls on 5/21/19 and bumped his/her head and there was no notification made to the RN, on 6/24 and 6/27/19 s/he got dizzy and fell. Resident #1 fell again on 7/9/19 after getting dizzy. Resident #1 also sustained falls on 7/18 and 7/29/19 in which s/he said that their left knee gave out. The resident went to the emergency department on 8/5/19, at their request, to find out why his/her left knee hurt and why they kept getting dizzy and it was found that the resident required medication adjustment to assist with hypotensive episodes that were causing the falls. There is no evidence that an RN provided instructions for the staff regarding the health needs of Resident #1. The owner confirmed at 10:30 AM on 9/4/19 that there was not an RN for the facility to contact.	R146		
R148 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.9.c (5) Assure that residents' medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that resident's medications are reviewed periodically. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include: During record review of the medical records, it was found that there is no signature on the medication administration record (MAR) that the	R148	The nurse is notified immediately of any medication changes, so the MARS has the proper supporting documents for the changes This is monitored every 3rd week of month by reviewing residents records	

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R148	Continued From page 7 care givers use to determine what medications are given to the resident. Further review of the record showed that the last visit from the Registered Nurse (RN) was in December 2018. The caregiver on duty on 9/4/19, at the time of the review, stated at 8:30 AM that the RN only checks the medications when a resident comes to the facility. S/he further stated that the owner copies the medications on the MAR from month to month and s/he stated that the information came from doctor orders and what was on the previous month's MAR. The owner confirmed at 10:30 AM that s/he reviews the medications for the residents and not an RN.	R148		
R155 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have a Registered Nurse on duty that assumed the responsibility for staff performance in the administration of medications in accordance with the home's policies. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include: Per review of the home's policies, they dictate the Registered Nurse (RN) responsibility for staff performance in the administration of resident medications. The policy was not adhered to, as	R155	R155 The staff who assist with medication have been competency medications tested & have passed their performance testing This is monitored ~~by~~ every 3rd week of month by reviewing residents records	

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R155	Continued From page 8 the home did not have RN coverage since December 2018. The policy for administration of psychotropic medication required the Abnormal Involuntary Movement Scale administered every six months for patients on psychotropic medications was not followed as there was no RN coverage. The policy for nurse oversight quotes the Vermont State Residential Care Home Licensing Regulations regarding medication administration which states; that the RN will assure that residents medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem (5.9.c(5)), assume responsibility for staff performance in the administration or assistance with resident medication per house policies (5.9.c(12) and 5.10.d(3)). It continues to include reference to teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications and potential side effects (5.10.d(3)(i)) and the assessing of the resident's condition and the need for any changes in medications, monitoring and evaluating the designated staff performance in carrying out the RN's instructions (5.10.d(3)(ii) and 5.10.d(iv). Per confirmation on 9/4/19 at 10:30 AM by the owner, the policies were not followed because there was not RN coverage for the facility since December 2018.	R155		
R161 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that	R161		

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R161	Continued From page 9 designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the manager of the home ensured that all medications were handled according to the home's policies. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include: Review of the home's policies for nurse oversight states that the Registered Nurse (RN) will assure that resident's medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem. The policies also include that the RN will assess the resident's condition and the need for any changes in medications and monitoring and evaluation the designated staff performance in carrying out the RN's instructions. Per care giver of Harvey House on 9/4/19 at 8:30 AM, s/he doesn't know when the medication tests were taken and said that the RN never came to pick them up. The owner confirmed on 9/4/19 at 10:30 AM, that there was no RN coverage for the home since December of 2018 and there had been no RN oversight of staff designated to administer medications. The staff took a medication administration quiz in 2019, but there are no dates to indicate when they were taken and no signature of who administered the quiz.	R161	R161 The RN visits monthly and if there are medication changes to be reviewed This is monitored every 3rd week of month by reviewing residents records	
R163 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 Medication Management	R163		

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R163	Continued From page 10 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a Registered Nurse conducted an assessment with the physician's diagnosis and orders of the resident's care needs for 1 of 5 residents, Resident #1. Findings include: Resident #1 was admitted to the facility on 3/6/19 and there is no evidence that an assessment was conducted by a Registered Nurse prior to unlicensed staff administering medications to Resident #1. Resident #1 was seen in the emergency department 8/5/19 and had changes in condition and medications, s/he also had an increase of his/her Clonidine (a medication used for hypertension) but did not have an RN review the medication change or the reason for the change. The owner confirmed at 10:30 AM on 9/4/19 that the facility did not have an RN for overview and assessments	R163	R163 The RN is notified Immediately of any medication changes to residents. This is monitored every 3rd week of month by reviewing residents records	
R165 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer	R165		

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R165	Continued From page 11	R165		

medications under the following conditions:

(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:

i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;

ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;

iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure that unlicensed staff did not administer medications without the direction of a Registered Nurse and without an assessment of the resident's condition and the need for any changes in medications for 5 of 5 residents, Resident #1, 2, 3, 4 and 5. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include:

Per interview on 9/4/19 at 8:30 AM, the caregiver of the home stated that s/he has been a medicated delegated staff member since 2003 and could not recall the last time an RN assessed his/her competency in medication administration. S/he further confirmed that Resident #1 was admitted on 3/6/19 and s/he did not think that an RN had been in to assess the resident. The

R165
Staff have all been medication delegated by the RN
This is monitored every 3rd week of month by reviewing residents records

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R165	Continued From page 12 caregiver also stated that Resident #1 had a change in medications after s/he went to the emergency department on 8/5/19 and had a change in his/her Clonidine. Resident #2 received a new order for Tylenol 500 milligrams twice a day and the order was from the doctor but did not think there had been an RN. The medication administration record indicated that the residents of the home were receiving medications and while on site, the caregiver obtained and administered medications for three residents. The owner confirmed at 10:30 AM on 9/4/19 that the staff that administer medications have been trained by the RN, but there has been no RN oversight since December of 2018 and any medication changes made were not reviewed by an RN.	R165		
R178 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that there is always sufficient number of qualified personnel available to provide the necessary care and to maintain a safe and healthy environment. This citation requires Immediate Corrective Action due to the risk to resident safety. Findings include:	R178	R178 Staff have been medication delegated and the RN is notified immediately of any medication changes This is monitored every 3rd week of month to keep records in order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0380	A. BUILDING: _____ B. WING _____	C 09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVEY HOUSE LTD	1860 MAIN STREET CASTLETON, VT 05735

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178	Continued From page 13 Review of the resident records, there is no evidence that a Registered Nurse (RN) oversaw the provision of care and development of plans of care. The facility has been without an RN to provide the nursing oversight and delegation of nursing tasks, including medication management. Unlicensed staff are providing nursing care and medication administration without any nursing oversight or supervision. There have been no RN visits since December 2018. Per interview on 9/4/19 at 8:30 AM, the caregiver of the home stated that the Registered Nurse (RN) s/he has been a medicated delegated staff member since 2003 and could not recall the last time an RN assessed his/her competency in medication administration. S/he further confirmed that Resident #1 was admitted on 3/6/19 and s/he did not think that an RN had been in to assess the resident. The caregiver also stated that Resident #1 had a change in medications after s/he went to the emergency department on 8/5/19 and had a change in his/her Clonidine. Resident #2 received a new order for Tylenol 500 milligrams twice a day and the order was from the doctor but did not think there had been an RN. The medication administration record indicated that the residents of the home were receiving medications and while on site, the caregiver obtained and administered medications for three residents. The owner confirmed at 10:30 AM on 9/4/19 that the staff that administer medications have been trained by an RN in the past, but there has been no RN oversight since December of 2018 and any medication changes made were no reviewed by an RN.	R178		